The Physician's Role in Building Healthy Communities

Keynote Address
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Good morning, and welcome to Baltimore and the Hilton Baltimore Hotel – right across the street from Camden Yards, the home of the American League-leading Baltimore Orioles! To those who are cynical about health care in the United States … if the Baltimore Orioles can be having this kind of season, anything is possible.

We're now coming up on the 13th anniversary of my last overnight shift as a resident. I celebrate this day every year by staying up all night, trying to decipher barely legible orders in pen and ink, and playing tetris.

As interns and residents, you see the health care system from a unique and important vantage point. Every system failure comes through your Emergency Department doors. You see the failed handoffs, the misunderstood instructions, the social causes of illness, and the avoidable tragedies that make it hard to get up in the morning, let alone come in for work.

But you also see how hard so many people in the medical field – nurses, techs, clerks, and yes, even attendings – work to save lives every day.

My topic is "The Physician's Role in Building Healthy Communities." I am sure many of you could give the lecture yourselves. There is a long tradition of interns and residents playing a key role in building healthy communities. And I'll define that term broadly: as caring about and fighting to improve the health of people beyond the patients right in front of you.

I'll start with some historical perspective and then talk about the incredible opportunities for community health engagement that are emerging today.

When my father was an intern in New York City, he and several of his fellow residents were incensed about a new charge that New York Medicaid was placing on every Emergency Department visit. So they held a press conference … in the Emergency Department … and told patients not to pay. I believe my father was quoted saying something like, "This may be the first time in history that doctors are telling patients not to pay their bills."

Apparently this action was supported by patients, but not by hospital management. Fortunately, the hospital's unions saved the day, by taking the side of my father and his colleagues.

When I was a resident in pediatrics, and a CIR member, we recognized that housing problems were at the root of many of our patients' medical issues. I remember caring for an obese 2-year-old boy whose mother kept him strapped into a stroller all day … because they were doubled up in an apartment and she was afraid that if he got into trouble, they would be asked to leave.

I recall numerous patients with asthma who needed a new apartment more than a new inhaler. When we put out the call for stories about kids whose housing was affected by their health, one doctor wrote in that smoking in the apartment next door was a problem – especially since the smoke came in through a large hole in the wall.

As one of the few doctors fluent in Spanish, I gave out my pager number to all my patients. One night, a mom called me to talk about her son Leo's cough. This was a mom who called me a few times a week with one issue or another. Yet I could sense something was different. He had a bad cough, she said, and shoulder pain. Shoulder pain? I sent them to the Emergency Department, where a massive mediastinal mass was discovered on x-ray. Within hours, he was getting radiation therapy for an acute lymphoblastic lymphoma.

Soon after the diagnosis, Leo's mom called me. Her number one concern was their housing situation. Leo shared a bed with his brother, they were overrun with cockroaches. Could I help her transfer to a better location? We worked with the Boston Housing Authority to help Leo and change the transfer policy for other families.

Eventually, we wrote a national research report called Not Safe at Home and teamed up with national advocates and Senator John Kerry to push, successfully, for additional funding for Section 8 vouchers. Some of you may know my co-conspirator in these efforts, Dr. Megan Sandel, who has devoted her career to research and intervention to improve housing and promote child health.

For Megan and me, there was no need to look far for the physician's role in community health. It's pretty much right in front of your face. The question is whether you can see it…and how to best respond.

About eight or nine years ago, an infant presented to a Philadelphia emergency department with an unusual rash, edema, and thinning hair. The dermatology team diagnosed kwashiorkor, protein calorie malnutrition. An admission and careful refeeding program saved the child's life.

But kwashiorkor, in Philadelphia? The doctors found out that the mother had been using a product called Rice Dream instead of milk. Without any protein in the diet, the result was kwashiorkor.

A little digging revealed that Rice Dream had been marketing itself at the time as complete nutrition and an alternative to milk. You'd practically have to be a nutritionist to know that using it in place of milk for an infant could lead to serious medical problems. The dermatology team searched the literature and found a number of cases of kwashiorkor related to rice products, including death.

So they wrote a paper, which they titled, "Rice Nightmare." Nothing changed. They called the Philadelphia Inquirer, which wrote a story. Nothing changed. They called some sympathetic Congressional staff, and an investigation ensued. The makers of Rice Dream and most other similar products responded quickly with a strong warning on the packages.

Take 100 doctors. Many would stop at making the right diagnosis and saving the life of this patient. After all, that's not bad for a day's work. Some would stop at writing the academic paper. Only a few would ask whether this could happen again and fixing the underlying problem.

But all could do so. Doctors have the ability to penetrate into a case and figure out what needs to happen to protect others. Those that take it as a challenge – as important a challenge as making the right diagnosis – can make major contributions to health beyond clinical care.

When I was serving as the Commissioner of Health in Baltimore, I chaired the child fatality review committee – whose charge was to revisit the unexpected deaths of all children in the city. It was, without a doubt, the most trying and difficult meeting on my calendar each month. The only way of coping was to ask the question – what can we learn from this horrific tragedy?

One day, I found out that several child deaths over the years in Baltimore had been attributed to overdoses of cough and cold medications – medications that I had learned as a resident did not work. I called a senior pediatrician at Hopkins and we drafted a statement that every pediatric chair in Baltimore signed. The statement called on parents not to use these medications for their children. The local chair of the chapter of the American Academy of Pediatrics joined us.

Our statement got a lot of publicity, and a number of people emailed me to ask – if these products are no good, why are they being sold everywhere? I assigned a medical student working with me to answer that question.

She reported back that the products never went through the approval process, and were being marketed pursuant to a monograph written more than 25 years earlier. With assistance from some national experts, we drafted a petition to FDA that led to the withdrawal of all cough and cold medications for children under age 4 from the market. Subsequent research showed an enormous drop in poison control calls after these changes took effect.

One of the doctors who made this possible was Dr. Michael Shannon, an inspiring toxicologist and Emergency Department physician from Boston Children's Hospital. I don't think we would have succeeded without his persuasive presentation to an FDA advisory committee. Soon after, Dr. Shannon called to tell me how much it mattered to him to see real policy changes that could protect millions of children. When he tragically died a short time later, I reflected on how he did everything he could to help us simply because it was the right thing to do. It was apart from his clinical and academic responsibilities.

Dr. Shannon set an incredibly high bar for engagement. One approach to the medical profession is to hope to see more people like him. Not a likely scenario. But another approach is to make such engagement easier and more expected of clinicians. And that is happening. Changes in the health care system are making involvement in community health far more integral to clinical, academic – and financial – success.

When I was the health commissioner of Baltimore, the fire chief came to me and asked for help with frequent 911 callers. We identified the top few callers and sent out home visitors. We learned that woman in her 90s called 911 every few days because she thought the EMTs were cute. Another man called often because he understood that after giving insulin to his wife, she was supposed to go unconscious. Some simple interventions – such as finding sufficiently cute home visitors and teaching about the right dose of insulin – dramatically reduced ambulance calls. Our efforts were cost saving in the ambulance system alone – let alone the health care system.

I recall presenting these results, which were later published, to the leaders of the city's emergency rooms. They were ecstatic. I hadn't seen such elation on an ER doctor's face since I was a resident and I had managed to get a difficult IV into a dehydrated child, sparing them the need to do so themselves. They wanted to see the program expanded. But they also knew that every ER visit prevented would deprive the hospital of revenue. The city has kept investing, but the hospitals never did.

As long as health care is paid fee-for-service and rewards volume instead of value, doctors' efforts at community health will be largely extra-curricular. But the ground is shifting.

One key driving force is cost. Health costs have passed the point of affordability for many families, small businesses, and units of government. In the private sector, many employers are adding high deductibles to keep the premiums affordable. But these plans raise concerns about whether all care will be deferred until the moment of crisis, defeating the purpose.

In the public sector, Medicare costs are the root of federal budget challenges, and Medicaid at the center of state conflicts.

There is broad, bipartisan consensus that we cannot continue on the same unsustainable path. Our goal is the triple aim: better outcomes, lower costs, and a better patient experience at the same time. These new incentives strongly align the health care system with community health … because better management of population health is a critical tool to achieve better outcomes at lower cost.

In Maryland, where we have the nation's only rate setting system for hospitals, we're taking a number of key steps to shift away from fee-for-service reimbursement. For example, a number of our rural hospitals are on global budgets. The fewer ER visits that happen, the more margin these hospital

make. These hospitals are working together to analyze data on high-cost patients and develop new partnerships with community agencies.

In addition, most of our other hospitals are now being paid a little more for each admission, but not being paid for many re-admissions within 30 days. Suddenly, it's the hospital's job to think about what can keep someone healthy and avoid bouncing back into care. My sister, an internal medicine resident, now says that discharge planning for a patient with heart failure is a lot more than an extra shot of Lasix out the door with the expectation the patient "will go wee, wee, wee all the way home." (I think she is a pediatrician at heart).

Within primary care, medical home initiatives offer a similar transformation … from being paid for each encounter to being paid based on effective and efficient management of chronically ill patients.

In Maryland, we're actively pursuing ways for community health efforts to team up with the health care system. Let me briefly discuss three key initiatives:

- Maryland's State Health Improvement Process. http://dhmh.maryland.gov/SHIP
- Our delivery reform workgroup and innovations initiative. http://dhmh.maryland.gov/innovations
- Health Enterprise Zones. A web page coming soon to http://dhmh.maryland.gov

There are doctors, hospitals, community health centers, and other health care organizations participating at all levels of these projects – developing and implementing innovative solutions to tobacco use, obesity, diabetes, infant mortality, and a broad array of health and social ills.

So yes, the challenges to health care in 2012 are greater than ever. But so too are opportunities for physicians to use their knowledge, advocacy, and creativity to make a difference. As CIR alumni, you will be at the forefront of these efforts. As always, the health of those you will support is at stake. Now, so too is the sustainability and success of our health care system.

No pressure, and thank you.